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IN THE CORONERS COURT FOR NORTHERN IRELAND

IN THE MATTER OF

AN INQUEST TOUCHING UPON THE DEATH OF MR DENIS JOHN DORAN

Before: Coroner Patrick McGurgan

[1] The deceased, Denis John Doran, born on the 14th January 1959, of 2 Woodville Glen, Lough Road, Lurgan, County Armagh, died on 19th November 2016.

[2] I am satisfied, based on the evidence at Inquest, that Article 2 of the European Convention on Human Rights (Article 2) is engaged so that the 'bow' in Rule 15(2) of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 is to be interpreted as meaning 'by what means and in what circumstances' the deceased came by his death.

[3] In his evidence to the Inquest, Dr Martin Stewart, retired GP, stated that the deceased had been a patient of his practice at the time of his death. He was an ex-smoker for 12 years and he also had a hiatus hernia with reflux diagnosed in 2002. He was also on a statin for hyperlipidaemia.

[4] Dr Stewart explained that from the notes and records the deceased attended the Emergency Department (ED) of Craigavon Area Hospital (CAH) at 6.30pm on 29th August 2016. The deceased had been experiencing chest pains for two months brought on by exertion at work or by walking and eased by rest. According to Dr Stewart the deceased's symptoms were more severe that morning which prompted the deceased to attend the ED department.

[5] Dr Stewart stated that the deceased subsequently attended his GP colleague, Dr Hagan, on 2nd September 2016. The deceased was concerned about his ongoing

symptoms of central chest pain on exertion relieved by rest. This was an appointment that the deceased's wife had made for the deceased some 6 weeks prior. Dr Hagan organised investigations including blood tests, an ECG and 24 hour blood pressure monitoring.

[6] I find that Dr Hagan also referred the deceased at this time to the Rapid Access Chest Pain Clinic.

[7] The deceased attended with his GP, Dr Stewart, on 22nd September to discuss his test results. According to Dr Stewart at that time the deceased was still experiencing episodes of chest pain with exertion which eased with rest. Tests were normal except for an elevated cholesterol level. The deceased had informed Dr Stewart that the hospital had discharged him with a diagnosis of chest pain due to his hiatus hernia. Dr Stewart's working diagnosis was that of stable angina and he made an immediate referral to the Rapid Access Chest Pain Clinic at CAH by fax that same evening. Dr Stewart also prescribed Aspirin 75mg daily and GTN spray and changed his cholesterol tablet. Dr Stewart also explained to the deceased how to use the GTN spray and that if it was proving ineffective on use to telephone 999 and request an ambulance.

[8] According to Dr Stewart the Rapid Access Chest Clinic waiting list was between 4-6 weeks. He understood that its ideal was to see patients within 2 weeks and that he was unaware that at this time the waiting list was one of 11 weeks due to staff shortages.

[9] Dr Stewart was of the view and I find that 11 weeks was too long for a patient such as the deceased to have to wait to be seen, that such a delay represented a risk to patient safety and that if the deceased had have been seen earlier in the clinic then there would have been a much better outcome here.

[10] I find that Dr Stewart acted in an appropriate and timely manner.

[11] In her evidence to the Inquest, Dr Cathy Cunningham stated that at the time she was a GP ST1 trainee working as a medical SHO in CAH. She stated that the deceased arrived at ED at 5.52pm and was triaged at 6.04pm and that he was assessed by Dr Samuel Okereke with a diagnosis of chest pain. The deceased was then referred to the medical team.

[12] I find that Dr Okereke acted appropriately and timely.

[13] Dr Cunningham reviewed the deceased at 03.46am on 30th August 2016 and following a full history to include that of a hiatus hernia and tests, Dr Cunningham decided that the deceased should have a chest x-ray, an ECG if there was a

reoccurrence of chest pain and he was to be reviewed on the post take ward round. Dr Cunningham explained that she also suggested a cardiology review take place the following morning as she could not order one at that time of the night/early hours.

[14] Dr Cunningham's working diagnosis was one of stable angina. The deceased's troponin value at 6.25pm was 21 and at 9.40pm it was 17. The normal reading should be less than 14.

[15] Dr Cunningham did not believe that the pain being experienced by the deceased was related to his hiatus hernia but was more in keeping with angina hence the reason why she suggested a cardiology referral although there was insufficient evidence to suggest that the deceased was suffering a heart attack.

[16] Dr Cunningham was of the view that the deceased would be seen later that morning at the ward round and reviewed by cardiology and then further tests conducted, most likely a treadmill test. Dr Cunningham was also of the view that an 11 week wait to be seen at the Rapid Access Chest Clinic could pose a risk to patient safety.

[17] I find that Dr Cunningham acted appropriately and timely throughout her involvement with the deceased.

[18] In her evidence to the Inquest, Dr Katherine McMillen, stated that at the time she was an ST5 and had been employed by the Southern Health and Social Care Trust since the 3rd August 2016. On the 30th August 2016 she was on duty from 8am until 5pm. At the post take ward round she was with Dr Mohammod Asaduzzaman (or Dr Asad as he referred to himself), locum Consultant. Dr McMillen understood from a conversation she had with Dr Asaduzzaman that he had background training in Cardiology and that she was under the impression that he was a trained cardiologist. Dr McMillen documented that the deceased had presented with chest pain on a background of hiatus hernia. Dr McMillen documented that the two troponins were normal and NEWS was normal.

[19] In her evidence Dr McMillen accepted that the deceased's symptoms were a classical presentation of angina and that the deceased's family history and background were all factors which increased the risk for the symptoms being heart related. Dr McMillen explained that on the morning in question she was acting as the scribe to Dr Asaduzzaman and recorded his findings that the ECG readings were normal. Dr McMillen was now of the opinion herself that they were not normal and that the elevated troponin levels would raise a suspicion of a coronary issue.

[20] Notwithstanding the fact that Dr McMillen was aware that Dr Cunningham and Dr Okereke both suspected a coronary issue and that she herself suspected same, she did not intervene or question Dr Asaduzzaman's diagnosis of chest pain secondary to a hiatus hernia. Dr McMillen explained that she simply assumed that due to her inexperience at that time that she had missed something subtle that Dr Asaduzzaman, the locum Consultant, had identified, particularly as she was under the impression that he had a background in Cardiology.

[21] Dr McMillen stated that if Dr Cunningham's suggestion of a Cardiology review had been followed then in all likelihood the deceased would have been seen that day by a Cardiologist or a member of the cardiology team and further tests conducted.

[22] Dr McMillen stated that she was aware that there was a Rapid Access Chest Pain Clinic but that she had never been informed that there was an 11 week delay at that time in patients being seen once referred.

[23] I find that Dr McMillen did act appropriately in the circumstances at the time. However, the evidence suggests that much more emphasis needs to be placed on the "jump policy" [my terminology] for junior members of staff particularly where they are placed with a locum consultant or doctor.

[24] In his evidence to the Inquest, Dr Mohammod Asaduzzaman stated that on the morning in question he had been working as a locum Consultant in Acute Medicine in Craigavon Area Hospital. He had taken up that post on 19th July 2016 until 8th March 2017. Immediately prior to this he had been working as a locum registrar in England from January 2016 until June 2016 having previously worked as a locum in various roles in Bangladesh and Saudi Arabia. Dr Asaduzzaman explained that this was his first locum Consultant post, that he had no formal interview for the position but simply that his CV had been forwarded to the Trust at their request by his recruitment agency. Dr Asaduzzaman did not undergo any induction process on arrival at Craigavon Area Hospital but simply attended for his shift and commenced work. I will return to this aspect of the evidence in due course.

[25] On the morning of 30th August 2016, Dr Asaduzzaman stated that he met with the deceased at the post-take ward round. He noted a past medical history of hiatus hernia and that he was being prescribed Lansoprazole 15mg once daily for indigestion and heart burn relief. He was also taking a statin in respect of his cholesterol. Dr Asaduzzaman explained that a clinical examination did not reveal any abnormality in his heart sounds or chest auscultation.

[26] Dr Asaduzzaman diagnosed non cardiac chest pain secondary to hiatus hernia and the deceased was discharged with no planned review or further investigations.

[27] Dr Asaduzzaman explained that he informed the deceased at the end of the examination to return to hospital or to his GP if he developed recurrent symptoms. Although this was not documented in the deceased's notes and records, Dr Asaduzzaman told the Inquest that he always, as a matter of practice, says this to patients.

[28] I find on the balance of probabilities that Dr Asaduzzaman did give this advice to the deceased although I find that the notes are lacking in this regard.

[29] In evidence, Dr Asaduzzaman accepted that he should have considered a cardiac cause as being a reason for the deceased's symptoms. He further accepted that the symptoms were a classical description of angina and that he made an error of judgement.

[30] Dr Asaduzzaman stated that on going to a patient on the ward round he would "flick" through the patient's notes. He could not offer an explanation as to why he made the diagnosis of chest pain secondary to hiatus hernia.

[31] Dr Asaduzzaman further stated that he was unaware of the Rapid Access Chest Pain Clinic as he had not received any orientation on commencing his post. He did explain that if a patient needed cardiology review that would have been carried out whilst the patient was an in-patient and therefore would not have been referred to the Rapid Access Chest Pain Clinic. He too was unaware that there was an 11 week delay in the Rapid Access Chest Pain Clinic.

[32] I find that Dr Asaduzzaman was not sufficiently qualified to perform the role of locum Consultant in Acute Medicine at the time. I find that Dr Asaduzzaman did not pay sufficient regard to the notes and records pertaining to the deceased, that he lacked the requisite training and experience required for this post and that he made an incorrect diagnosis and as a result of the incorrect diagnosis no follow up investigations were ordered and no cardiology review sought, all of which I find represented a loss of opportunity in respect of the care and treatment of the deceased.

[33] In addition, I find that there was a completely inappropriate appointment process, particularly for the senior role of Consultant in Acute Medicine. I find that there was no interview, no induction, no proper orientation and insufficient

scrutiny/enquiry by the Southern Health and Social Care Trust (The Trust) of Dr Asaduzzaman's training, qualifications and experience to include his limitations.

[34] Dr Paul McGlinchey, Consultant Cardiologist was instructed by the Coroner. He noted that the deceased attended the ED of CAH on 29th August 2016 with chest pain on exertion radiating to the arms and jaw. A two month history of intermittent chest pain whilst walking or on exertion was documented. The deceased was an ex-smoker, was being treated for hypercholesterolaemia and there was family history of coronary heart disease in that his father had suffered a myocardial infarction.

[35] Dr McGlinchey noted that the deceased was subsequently assessed by Dr Mohammed Asaduzzaman, Locum Consultant in Acute Medicine. In his evidence Dr McGlinchey was of the opinion that this was a clear presentation of angina which Dr Asaduzzaman missed.

[36] In respect of Dr Asaduzzaman's training, Dr McGlinchey was of the view that he did not have satisfactory experience to be a Consultant in the UK but that the rules surrounding the appointment of locums are less stringent. Dr McGlinchey was further of the opinion and I find that the fact that Dr Asaduzzaman made an incorrect diagnosis of chest pain secondary to hiatus hernia rather than a cardiac related issue provided false reassurance to the deceased and his family.

[37] In Dr McGlinchey's opinion if the deceased had have been properly diagnosed then in all likelihood the deceased would have underwent appropriate treatment within a matter of 1-2 days and that this treatment would, on balance, have avoided his death.

[38] Dr Michael Moore, Consultant Cardiologist at Craigavon Area Hospital gave evidence to the Inquest. He had been asked to Chair the Serious Adverse Incident investigation which the Trust conducted following the death of the deceased. Dr Moore and the review team believed that the deceased had presented with symptoms classical of cardiac chest pain and that Dr Asaduzzaman should have considered a cardiac cause for the pain and referred the deceased to the cardiologist.

[39] Dr Moore explained that it was simply a matter of "pot luck" as to whether a patient was seen by a locum Consultant or by a permanent Consultant as both would be examining the same cohort of patients.

[40] Dr Moore explained that in relation to the Rapid Access Chest Pain Clinic, the target time to see a patient is two weeks. He was unaware that that target time had reached as far as 11 weeks at the time. This was due to the fact that at the time there were two trained nurses in that clinic one of whom had gone off on sick leave. The

clinic is now staffed by three trained nurses. However, in Dr Moore's opinion, the deceased was not an appropriate candidate for the Clinic in any event as he was already a high risk patient and he would have taken him straight to angiography. This would have occurred within 72 hours of being seen by cardiology.

[41] Dr Moore was also of the opinion that Dr Asaduzzaman would not have been eligible for a Consultant's post in the UK.

[42] In relation to the operation of the Rapid Access Chest Pain Clinic, I find that if it had been meeting its target time of two weeks then the deceased would have been seen, if not following the first GP referral on 2nd September then certainly following the second GP referral on 22nd September. I find that the delay of 11 weeks represented a missed opportunity as regards the care and treatment of the deceased.

[43] The Trust provided evidence following the conclusion of the oral hearings in relation to the number of deaths of patients who were on the Rapid Access Chest Pain Clinic waiting list. I have considered this evidence. The Trust advised that during this time, some thirteen deaths occurred of patients waiting to be seen by the Rapid Access Chest Pain Clinic. Six of these deaths were as a result of a cardiac event. As I have already outlined above, this delay posed a risk to patient safety and I find that in this case represented a missed opportunity in the care and treatment of the deceased.

[44] The evidence suggests that there was an insufficient contingency plan in place by the Trust to deal with a situation of a staff member going on sick leave from the Clinic thus reducing the staffing complement by 50%. I commend the Trust for now having addressed this issue by recruiting a third member of staff.

[45] I find that there was no communication between the Trust and its staff or stakeholders regarding the delays being experienced in the Rapid Access Chest Pain Clinic. The evidence further suggests that all relevant staff and stakeholders should be informed in a timely manner about such delays so that alternatives can be considered by those stakeholders.

[46] As regards the selection and appointment of locum Consultants and or doctors, I find that the system in operation is completely inappropriate. Whilst I acknowledge the pressures Trusts are under in order to fill "gaps" in services the evidence suggests that this cannot be at any cost. The evidence further suggests that there needs to be an immediate review of how locums are selected and appointed with proper interview processes put in place together with robust background checks particularly as regards training and competency.

[47] A post-mortem was performed and it records and I find that death was due to:

I (a) Recent Myocardial Infarct;

Due To;

(b) Coronary Thrombosis; Due To;

(c) Coronary Atheroma.

[48] I find on the balance of probabilities that this death was preventable. I find that if the deceased had received a proper diagnosis whilst an in-patient on the Acute Medical Ward, then the appropriate cardiac investigations and treatment would have followed resulting, on balance, in a different outcome.

[49] I further find that if there had not been the 11 week delay at the time with the Rapid Access Chest Pain Clinic then the deceased, following either of the two GP referrals, would have been seen in a timely manner and appropriate tests and investigations conducted, again resulting, on balance, in a different outcome.